

**NATIONAL ACADEMY OF SOCIAL INSURANCE ISSUES  
NEWEST REPORT ON WORKERS' COMPENSATION  
*BENEFITS, COVERAGE, AND COSTS***

Annually, the National Academy of Social Insurance of Washington, D.C. produces a report that reviews and analyzes workers' compensation benefits, coverage, and costs. This recent report presents the most current data available, 2004, on developments in workers' compensation on a national level.

The Trust believes that it is important for all our members and clients alike to be informed on what's happening across the country with workers' compensation costs. Key highlights from the report are as follows:

In 2004, employers' costs for workers' compensation grew faster than combined payments for cash benefits and medical treatment for injured workers. Total cash benefits and medical payments were \$56 billion in 2004, an increase of 2.3 percent over the 2003 amount of \$54.7 billion. At the same time, employer costs rose to \$87.4 billion from 81.7 billion in 2003, an increase of 7 percent. For self insured employers, costs were calculated as benefits plus administration costs. For those employers who purchased insurance, costs were calculated as payments made for premiums and for benefits paid under insurance policies with large deductibles.

The share of benefits for medical care varied among states. In 2004, the share of benefit spending, for medical care, ranged from lows less than 40 percent – in the District of Columbia, **Connecticut**, Hawaii, Massachusetts, Michigan, New York, Rhode Island and Washington – to highs of over 60 percent in Alabama, Arizona, Arkansas, Indiana, South Dakota, Texas, and Utah. Many factors in a state can influence the relative share of benefits for medical care. For example, differences in

*(continued on Page 2)*

**INSIDE THIS ISSUE**

- 2 **Employers Role at Informal Workers' Compensation Hearing**
- 2 **Hospital Risk Manager Elected President of RIMS**
- 3 **Obesity: A Heavy Burden on Workers' Compensation Claims**
- 4 **Sit / Stand / Lift**
- 5 **Educational/Focus Calendar**
- 6 **Safety Committee and Managed Care Plan Requirements**
- 6 **Staff Changes**
- 7 **Preventing Fire**
- 8 **Acquired Immune Deficiency Syndrome (AIDS)**

medical costs, medical practices, and the role of workers' compensation programs in regulating allowable medical costs.

A total of 1.3 million workplace injuries and illnesses that required recuperation away from work, beyond the day of the incident, were reported in private industry in 2004. The number of reported injuries or illnesses per one hundred full time workers with any days away from work declined for the thirteenth year in a row from 3.0 in 1992 to 1.4 in 2004. The median time away from work, beyond the day of the injury, was eight days.

So what are these facts and figures telling us about the state of workers compensation when we look at it on a national level? It appears that, despite a steady decline in the number of reportable work related accidents occurring over the past decade or so, workers' compensation costs for employers and benefits paid out to injured workers' and medical providers who treat them remain on the rise.

The Trust is committed to doing all possible, to reduce the cost of workers' compensation for our members and clients.

If any Trust member is interested in obtaining more detailed information on the Academy's report, please contact Brian Downs, Director of Provider Relations at (203) 678-0103.

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## **THE INFORMAL HEARING**



In 2005, Trust Hearing Representatives attended 511 Informal hearings throughout the eight State districts. Informal hearings stem from issues that cannot be resolved between the injured employee and the Trust. The Notice of Hearing identifies the issue to

be addressed; although there is always a chance that another issue may be brought up at a hearing, or new medical information is presented that was not expected.

At the informal hearing, the Hearing Representative represents the interest of both the Employer and the Trust. There are times, however, when it is beneficial for the Employer to attend the hearing as well. In these cases, the claims representative will contact the employer to request their presence. A pre-hearing conference will be held in order to ensure that both the Employer and the Trust are of the same understanding. The Trust's Hearing Representative will be the one to present the facts to the Commissioner at the actual hearing. The Employer's role would be to respond to any questions in a factual, non-confrontational manner.

Once both sides present their response to the issue, the Commissioner will make a non-binding recommendation which hopefully would resolve the issue. If the issue remains in dispute a pre-formal hearing would likely be scheduled. More information on the pre-formal hearing process will be in the next issue of the Newsletter.

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## **HOSPITAL RISK MANAGER ELECTED PRESIDENT OF RIMS**

Michael Liebowitz, Director of Risk Management and Safety for the Bridgeport Hospital and Healthcare System, is the first-ever hospital risk manager to be elected president of the Risk and Insurance

Management Society (RIMS). The Risk and Insurance Management Society, Inc. (RIMS) is a not-for-profit organization dedicated to advancing the practice of risk management, a professional discipline that protects physical, financial and human resources.

Congratulations Mike!

# OBESITY A HEAVY BURDEN FOR WORKERS' COMPENSATION CLAIMS



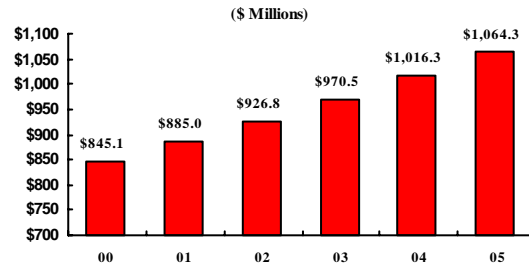
According to the National Center for Health Statistics, U.S. workers have become more obese over the past 15 years. In the early 1990s, only 20 percent of the workforce was classified as obese. Today, nearly 30 percent of workers are obese, 36 percent are defined as overweight and only 34 percent maintain a normal body weight. The Center classifies obesity as 30 or higher on the Body Mass Index (BMI).

Obesity is an important issue among the American workforce, and there is no doubt that the declining health of employees has a direct impact on workers' compensation claims. Over the past several years, a number of well documented studies has demonstrated that obese employees are more prone to injuries and illnesses than their slimmer counterparts, with slower recovery time resulting in higher workers' compensation costs.

The Insurance Information Institute recently published figures using estimates extrapolated from a 2005 California State Department of Health Services study on the economic costs of physical inactivity and obesity in California adults to estimate the financial impact of obesity on US Workers' Compensation Systems. The projected cost, outlined below, is alarming with the 2005 projection of over 1 billion dollars. Moreover, researches have concluded that if present trends continue, the related costs will continue to increase due to population growth, aging, and higher rates of children who are obese and will eventually enter into the workforce. Lastly, add double digit medical inflation to this equation and there

is no doubt that this issue is of concern to all in the workers' compensation industry.

## Estimated Cost of Obesity on U.S. Workers' Compensations Systems



Obesity and other weight-related conditions are becoming a constant problem among American workers and there is clear evidence to suggest that it can negatively impact an employer's workers compensation program. Experts say that employers can help reduce employee obesity and its related health costs whether covered by workers' compensation or group health insurance by providing low-cost preventative solutions, such as offering healthier food choices in vending machines, cafeteria menus and office meetings, improving access to physical activity at the work site and providing incentives for workers to lead healthier lifestyles.

A wellness program is a meaningful investment in a company's greatest resource, its employees. To help employees with workplace wellness, employers should encourage the following five steps:

- Encourage awareness of unhealthy behaviors;
- Support a winning attitude to help overcome difficulties;
- Commit to success;
- Believe in the importance of good health and maintaining healthy habits;
- Emphasize a consistent behavioral change.

If any Trust member is interested in learning more about the California study on the economic costs to workers' compensation

*(continued on Page 4)*

systems due to physical inactivity and obesity, or the benefits of implementing a company sponsored wellness program, please contact Brian Downs, Director of Provider Relations at (203) 678-0103.

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## **SIT / STAND / LIFT**



Sit-to-stand patient lifts are crucial in preventing the development of disabling injuries to both the healthcare workers and the patient/resident.

In assisting the elderly or persons with disabilities to stand from a seated position, there are a number of risks to both healthcare workers and patient/residents. Patients/residents may be prone to falls, placing the healthcare worker at risk of an injury while managing the fall. The frailty of the patient/resident in being manually assisted poses a risk of fracture, shoulder dislocation or skin tears.

There is a safer way to assist patients/residents to achieve a standing position through affordable sit-to-stand lifts.

The sit-to-stand patient lift is a mobile lift that allows patients to be transferred from a seated position to a standing position and vice versa. It is also used for bed to chair transfers, toileting and perineal care. The advantage of this lift is that it minimizes back and shoulder injuries associated with lifting or moving patients when entering or exiting a seated position.

The sit-to-stand patient lift differs from total body lifts in that the patient must be cognitive and provide some cooperative input. The patient must be partial weight bearing and possess some muscle tone in at

least one leg and the trunk. No upper body muscle tone is required.

The sit-to-stand lift is an improvement for the patient in terms of physiological and psychological benefits compared with the than total body lifts since the patient is participating in the transfer. The patient's mental acceptance of a sit-to-stand lift is much greater than other total lifts. These lifts can also greatly reduce patient skin shearing or tears.

Care givers find the sit-to-stand lift much quicker and easier to use than other full body sling lifts. Care givers who use the sit-to-stand lifts on a regular daily basis, instead of performing manually assisted sit-to-stand transfers, such as with gait belts, greatly reduces the potential for repetitive trauma that can result in musculoskeletal injuries; especially to the back and shoulder. Care givers have the highest rate of back injuries in the private sector according to OSHA statistics, which results in increased workers compensation costs and indirect costs to the employers.

Studies have shown that the ratio of patient assisted lifts (such as a sit-to-stand lift) to total body non-assisted lifts in health care facilities is about 3:1, or simply put, 75% of transfers are patient assisted. Therefore, sit-to-stand lifts can be very beneficial in improving patient transfer procedures for both the patient and care giver. A true "Zero Patient Lift" facility policy would require the use of a mechanical lift for all patient assisted patients who are partial weight bearing, thereby eliminating the stress to a care giver's back and shoulder from manual transfers techniques. This would require three sit/stand lifts for every one total lift, depending on the patient population.

### **Sit-to-Stand Lift Advantages**

- Excellent physical/psychological benefits for the patient
  - Versatile – can be used in several rooms
- (continued on Page 5)*

- More dignified, less intimidating to the patient
- Excellent for toileting, perineal care
- Reduces patient skin shear/tear injuries
- Eliminates patient falls from manual transfer procedures
- Faster and easier for the care giver, requires only one person
- Eliminates care giver injuries from patient falls or sudden patient movements during manual transfers
- Reduces back/shoulder injuries to care givers from the cumulative trauma of daily repetitive manual patient transfers
- Reduces WC costs, employee lost time and the indirect costs associated with employee injuries
- Increases employee morale, productivity and job satisfaction

*Remember, the cost of one lift, approximately \$5,000-\$6,000, can easily pay for itself when compared to the cost of an average back injury, about \$30,000. The increased use of lifts such as sit-to-stand lifts in health care facilities is by far the most cost effective means to reduce employee injury rates and control worker' compensation costs.*

For additional information contact your Loss Control Representative or  
**Patient Lifts of New England**  
 Toll free: 1-800 987-6219 X 23



**NEW MEMBERS**

Kenny Homemaker & Companion, LLC  
 New England Nightingales Home Care  
 Community Action Agency of New Haven  
 Comfort & Care of Wallingford, LLC  
 March, Inc. of Manchester  
 United Cerebral Palsy Assoc. of Southern CT

**RETURNING MEMBERS**

ATB LLC dba Action Nursing  
 Southeastern Council on Alcoholism & Drug Dependence, Inc.

**EDUCATIONAL CALENDAR**

**NATIONAL SAFETY COUNCIL  
 DEFENSIVE DRIVING 4-HOUR  
 COURSE**

SEPTEMBER 20, NOVEMBER 8  
 8:00 a.m. – 12:30 p.m.

**ORIENTATION TO TRUST SERVICES**

SEPTEMBER 21, NOVEMBER 16  
 9:00 – 11:30 a.m.

**SEXUAL HARASSMENT SUPERVISOR  
 TRAINING**

OCTOBER 5  
 1:00 – 4:00 p.m.

**OSHA ERGONOMICS FOR PATIENT  
 HANDLING**

SEPTEMBER 27  
 9:00 – 11:30 a.m.

**FOCUS GROUP CALENDAR**

**WORKPLACE SAFETY MANAGEMENT  
 SEMINAR**

OCTOBER 19  
 9:00 a.m. – 3:30 p.m.

**HOSPITAL FOCUS GROUP**

SEPTEMBER 26, DECEMBER 12  
 9:00 – 11:00 a.m.

**GROUP HOME/COMMUNITY  
 ORGANIZATION FOCUS GROUP**

NOVEMBER 9  
 9:00 – 11:00 a.m.

**LONG TERM FACILITY  
 FOCUS GROUP**

OCTOBER 12  
 9:00 – 11:00 a.m.

**VNA/NURSING/HOME HEALTH CARE  
 FOCUS GROUP**

OCTOBER 26  
 9:00 – 11:00 a.m.

## **SAFETY COMMITTEE AND MANAGED CARE PLAN REQUIREMENTS**

One of the requirements of the Connecticut Workers' Compensation Commission's Medical Care Plan is an active Safety & Health Committee.

Administrative Regulation # 31-40v. defines the Safety & Health Committee. The purpose is to promote health and safety in the workplace and to bring employers and employees together in a non-adversarial, cooperative and effective effort to promote safety and health at each work site.

Some of the requirements in this regulation are:

- An employer who has **25 or more** employees at **any single work site** shall establish and administer a Safety & Health Committee **for that work site**.
- The Committee shall be composed of at least as many employee members as employer members and must be representative of the major activities at the work site
- A Committee member shall be elected as Chairperson
- The Committee shall meet at least once **every 90 days**

It is important that a member whose business has grown past the 25 employee size, at any work site or who has added new work sites, ensures that a Safety & Health Committee is established according to the regulation.

**We encourage all Trust members review their Safety & Health Committee(s) to be sure they are in compliance with the regulations.**

## **INTRODUCING NEW STAFF**

**Debbie Sanchioni**  
Senior Claims Representative

Debbie brings over seven (7) years experience in workers' compensation administration. She graduated with a Bachelor of Science Degree from the University of Connecticut and also is certified as a disability management specialist. Debbie will be responsible for handling self-insured accounts in the third party administration claims unit.

**Florence Marra**  
Senior Claims Representative

We welcome Flo back to the Trust. She brings twenty (20) years of workers' compensation claims administration experience. Flo has worked extensively with Connecticut health care providers and municipalities in reducing injury costs. She will be responsible for handling claims in the fully insured program.



## TRUST SUPPORTED PRODUCTS

### Ergonomic Patient Handling Aids

Phil-E-Slide Incorporated  
9 Industrial Way  
Atkinson NH 03811  
Contact Keith F. Boucher, CEO  
Toll free: 1-866-675-4338 Ext. 22  
E-mail: [kboucher@phil-e-slide-us.com](mailto:kboucher@phil-e-slide-us.com)

### Patient Ceiling Lift, Floor and Sling Equipment

Patient Lifts of New England  
9 Industrial Way  
Atkinson NH 03811  
Contact Richard C. McConnell, Account Executive  
Toll free: 800 987-6219 Ext. 23  
E-mail: [rmcconnell@bfine.com](mailto:rmcconnell@bfine.com)

### Safety Videos for the Healthcare Industry

Coastal Training Technologies  
Healthtrain Division  
500 Studio Drive  
Virginia Beach, VA 23452  
Contact: Diane Lee, Account Executive  
Telephone: 800-729-4325, Extension 3193  
E-mail: [diane@coastal.com](mailto:diane@coastal.com)

### Outdoor Footwear

Non-Slip Snow Grabbers  
These fit over your employees' shoes and are available for \$2.25 per pair, minimum 144 pairs.  
Bandwagon  
Telephone: 978-658-6252, ask for Cathy

### Indoor Footwear

Shoes for Crews, Inc.  
1400 Centrepark Blvd.  
West Palm Beach, FL 33401-7403  
Contact: Angelina Lanza  
Telephone: 800-218-4770, Extension 5133  
E-mail: [healthcaresales@shoesforcrews.com](mailto:healthcaresales@shoesforcrews.com)

### Employment Screening

Hettrick, Cyr & Associates, Inc.  
287 Main Street  
East Hartford, CT 06118  
Telephone: 860-68-2999

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## TRUST HELPS MEMBER PREVENT FIRE



A Senior Loss Control Representative noticed an electric space heater leaning up against flammable items while conducting a facility hazard assessment in a recently renovated building. The heater did not have a tip over safety shut-off switch and could have ignited the flammable material which was already hot to the touch. The faulty electric heater was removed from the premises.

On investigation it was discovered that an employee brought in the faulty electric heater from home without notifying the employer. The employer had previously issued safe portable electric heaters to employees within the office. The Senior Loss Control Representative recommended that the employer develop a policy prohibiting use of unapproved appliances (heaters, coffee pots, toasters and microwaves) without the prior approval of a designated management employee.

# ACQUIRED IMMUNE DEFICIENCY SYNDROME

(AIDS)

Mark Russi, MD, MPH  
Medical Director



Of the many diseases in the world and in workplaces with which we have grappled during the past quarter century, none has compared in scope or magnitude as the Acquired Immune Deficiency Syndrome (AIDS). June, 2006, marked the 25th anniversary of the first diagnosis of AIDS, and we now live in a world where over 40 million people are infected with HIV (1 million of whom reside in the U.S.), where 20 million have already died from the disease, and where approximately 5 million new infections occur annually. Although HIV transmissions in U.S. healthcare facilities are thankfully quite rare, few occupational exposures are as unnerving to a healthcare worker as a needlestick or splash to mucous membranes with HIV-positive blood. It is worth reviewing briefly some of the interventions undertaken over the past 25 years to minimize the likelihood of occupational HIV transmission, interventions which have made healthcare institutions safer places to work.

A number of guidelines and regulations have been designed to reduce bloodborne exposures among healthcare workers. Universal Precautions, developed by the CDC in 1987, were incorporated into the OSHA Bloodborne Pathogen Standard of 1991, along with a requirement for annual training, exposure reduction plans, engineering controls, and provision of hepatitis B vaccine to potentially exposed healthcare workers. In 1995, Standard Precautions were introduced, combining Universal Precautions with body substance isolation, to establish a single set of procedures for patient care and handling of blood and potentially infectious body fluids. Standard Precautions included use of barrier protections, such as gloves, gowns, and facial protection, where exposures to blood or body fluids may occur. They also included basic elements of infection control, such as handwashing and proper sharps disposal. Fundamental to the concept of Standard Precautions has been the assumption that all blood and body fluids,

except sweat, are potentially infectious, regardless of the infectious status of the patient.

Substantial evidence has accumulated that needlestick injuries can be reduced through educational programs and replacement of standard instruments with safer devices. Significant reductions in injury rates have been demonstrated for phlebotomy devices with engineered safety features and for needleless intravenous delivery systems. Reductions in the rates of percutaneous injury among operating room staff following implementation of blunt needles for certain procedures have also been documented. Based on the potential for safer devices to reduce bloodborne pathogen exposures among HCWs, the OSHA Bloodborne Pathogens Standard was amended in 2001 to require that employer's document consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure. Employers are also required to maintain a sharps injury log containing information regarding the type and brand of device involved in an exposure incident, and an explanation of how and where the incident occurred.

In addition, the CDC developed guidelines in 1996 for the administration of antiretroviral medications for healthcare workers significantly exposed to HIV-positive blood or body fluids. Those recommendations have been updated on several occasions since then, most recently in 2005, and have dictated standard practice following workplace bloodborne exposures.

In 1981, before the epidemiology of HIV was understood, some healthcare workers refused to care for patients with AIDS. Thankfully as the transmission characteristics of the virus were revealed, healthcare workers --with rare exceptions-- have stepped up to their responsibilities and rendered compassionate care to AIDS victims worldwide. While the interventions described have made work in healthcare facilities a safer undertaking than many imagined it might be in the early 1980s, let us never forget that healthcare workers go to work every day facing a hazard which could profoundly impact their lives and those of their families, and let us continue to be diligent in taking what steps we can to minimize that hazard.